AUTHORIZATION TO RELEASE
MEDICAL INFORMATION AND DISCLOSURE
OF PROFESSIONAL AND PERSONAL INFORMATION

Name:_____

SSN: _____

By this document, the undersigned hereby authorizes the Ohio Department of Developmental Disabilities to inspect and make copies of any and all reports, records, files and information maintained by any hospital, physician, insurance company, pharmacy, school board, employer (past or current), U.S. Defense Department, Veteran's Administration, Social Security, or any agency of any state, or employee of any of the above.

This authorization specifically includes alcohol, drugs, psychiatric, HIV and AIDS reports, records, files and, information.

The undersigned waives and releases any of the above sources or facilities from any restrictions imposed by law thereof, in disclosing or revealing any records, observation, diagnosis, or communication to the Ohio Department of Developmental Disabilities.

I also agree that a photocopy of this authorization may be used in place of the original.

_____
Name

_____
Date Signed